

PLEASE PRINT OR TYPE

**APPLICATION FOR RENTER'S  
REBATE OF ELDERLY RENTERS  
AND TOTALLY DISABLED PERSONS**

(rental year)

**RENTER**SEE INSTRUCTIONS AT ASSESSOR'S  
OR LOCAL SOCIAL SERVICES OFFICE

FILING PERIOD MAY 15 - SEPT. 15

|  |   |   |  |  |                  |                |  |  |
|--|---|---|--|--|------------------|----------------|--|--|
| 1. NAME (Last)   | (First)   | (Middle Initial)                              | YOUR BIRTH DATE (MO. Day. Yr.)   | YOUR SOCIAL SECURITY NO.   |                  |                |  |  |
|  |   |   | / /  | - -  |                  |                |  |  |
| 2. SPOUSE'S NAME (Last)  | (First)   | (Middle Initial)                              | SPOUSE'S BIRTH DATE (Mo. Day. Yr.)   | SPOUSE'S SOCIAL SECURITY NO.   |                  |                |  |  |
|  |   |   | / /  | - -  |                  |                |  |  |
| 3. PRESENT MAILING ADDRESS (No. and Street)  |   |   | CITY OR TOWN (Don't Abbreviate)  | STATE ZIP CODE   |                  |                |  |  |
| 4. RENTAL ADDRESS IN CT IF DIFFERENT THAN ABOVE  |   |   | CITY OR TOWN   | STATE ZIP CODE   |                  |                |  |  |
| 5. FILING STATUS:  |   |   |  |  |                  |                |  |  |
| CHECK ONLY ONE: <input type="checkbox"/> MARRIED <input type="checkbox"/> UNMARRIED <input type="checkbox"/> SURVIVING SPOUSE (AGE 50 TO 65) PROOF REQUIRED  |   |   |  |  |                  |                |  |  |
| IF SPOUSE IS A RESIDENT OF A HEALTH CARE<br>OR A NURSING HOME FACILITY IN CT <b>AND</b><br>ON TITLE <u>XIX</u> PROOF REQUIRED CHECK HERE: <input type="checkbox"/>   |   |   | IF APPLICANT IS TOTALLY<br>DISABLED <u>CURRENT</u> PROOF REQUIRED:<br>CHECK HERE: <input type="checkbox"/> |  |                  |                |  |  |
| 6. WHAT % OF RENT AND UTILITIES DO YOU PAY? (Husband and Wife are considered to be one (1) renter) %   |   |   |  |  |                  |                |  |  |
| 7. TOTAL RENT AND UTILITIES YOU ACTUALLY PAID. \$  |   |   |  |  |                  |                |  |  |
| 8. DID OR WILL YOU FILE A FEDERAL TAX RETURN FOR LAST YEAR? <input type="checkbox"/> - YES (Attach Copy) <input type="checkbox"/> - NO   |   |   |  |  |                  |                |  |  |
| 9. <u>PUBLIC ASSISTANCE RECIPIENTS PLEASE NOTE:</u> You may receive LESS than the TENTATIVE GRANT on<br>Line 20 below.   |   |   |  |  |                  |                |  |  |
| 10. DID YOU RENT IN CONNECTICUT<br>FOR THE ENTIRE CALENDAR YEAR? <input type="checkbox"/> YES <input type="checkbox"/> NO  |   |   | 11. IF THE ANSWER TO (10) IS "NO",<br>ENTER DATES YOU RENTED:  | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Starting Mo. Yr.</td> <td style="width:50%;">Ending Mo. Yr.</td> </tr> <tr> <td> </td> <td> </td> </tr> </table> | Starting Mo. Yr. | Ending Mo. Yr. |  |  |
| Starting Mo. Yr.   | Ending Mo. Yr.  |   |  |  |                  |                |  |  |
|  |   |   |  |  |                  |                |  |  |
| 12. INCOME RECEIVED DURING LAST CALENDAR YEAR:   |   |   |  |  |                  |                |  |  |
| A. GROSS INCOME - Includes: Federal Adjusted Gross income or its equivalent. Also includes, but is not limited to,<br>wages, lottery winnings, taxable pensions, IRA's, interest, dividends and net rental income. A. \$ _____ |   |   |  |  |                  |                |  |  |
| B. NON-TAXABLE INTEREST - Example: Interest from Tax Exempt Government Bonds B. \$ _____   |   |   |  |  |                  |                |  |  |
| C. SOCIAL SECURITY OR RAILROAD RETIREMENT INCOME - Add Medicare premiums (Attach SSA 1099) C. \$ _____   |   |   |  |  |                  |                |  |  |
| D. ANY INCOME NOT REFLECTED IN THE ABOVE - Examples: Federal Supplemental Security Income,<br>Veteran's Pensions, Veteran's Disability Payments, and any other income not listed above. D. \$ _____                            |   |   |  |  |                  |                |  |  |
| SPECIFY SOURCE OF INCOME: _____ E. <b>TOTAL</b> Add lines 12A through 12D E. \$ _____  |   |   |  |  |                  |                |  |  |
| APPLICANT'S/<br>AUTHORIZED<br>AGENT'S<br>AFFIDAVIT   | The applicant or authorized agent deposes that the above statements are true and complete and claims tax relief under provisions of the Connecticut General<br>Statutes. The property for which tax relief is claimed, is the permanent residence/domicile of the applicant. He/she is not receiving State Elderly tax benefits<br>under section 12-129b, section 12-170aa, in any town. I grant permission to the Department of Social Services to release to the Office of Policy and<br>Management information necessary to help determine my eligibility. The penalty for making a false affidavit is the refund of all grants improperly taken<br>and a fine of \$500.00 or imprisonment for one year, or both. Your signature signifies that this affidavit has been read and understood. |   |  |  |                  |                |  |  |
| SIGNATURE OF APPLICANT OR AUTHORIZED AGENT<br>X  | Date signed ( Mo. Day. Yr.)<br>____/____/____   | APPLICANT'S OR AGENT'S PHONE NO.<br>( ) _____ | AGENT'S RELATIONSHIP   |  |                  |                |  |  |
| <b>STOP! DO NOT WRITE BELOW THIS LINE - FOR ASSESSOR'S USE ONLY</b>  |   |   |  |  |                  |                |  |  |
| 13. Amount of rent and utilities paid from Line 7 \$ X.35 \$   |   |   |  |  |                  |                |  |  |
| 14. CREDIT COMPUTATION: QUALIFYING INCOME  |   |   |  |  |                  |                |  |  |
| <input type="checkbox"/> FULL YEAR-\$ x.05 OR <input type="checkbox"/> PART YEAR - \$ X (No. of Months / 12) x.05 = \$   |   |   |  |  |                  |                |  |  |
| 15. Subtract Line 14 from Line 13. If zero or negative amount, there is no benefit. Enter -0- on Line 20. \$   |   |   |  |  |                  |                |  |  |
| 16. Indicate table used: <input type="checkbox"/> Unmarried <input type="checkbox"/> Married   |   |   |  |  |                  |                |  |  |
| 17. MAXIMUM CREDIT ALLOWED   |   |   |  |  |                  |                |  |  |
| A. <input type="checkbox"/> FULL YEAR: amount per table OR B. <input type="checkbox"/> PART YEAR: amount per table X (No. of Months/12) = \$   |   |   |  |  |                  |                |  |  |
| 18. Enter amount from Line 15 or Line 17, whichever is LESS \$   |   |   |  |  |                  |                |  |  |
| 19. Minimum per table \$   |   |   |  |  |                  |                |  |  |
| 20. Enter GREATER of Line 18 or 19 TENTATIVE GRANT (Subject to review by Off. of Policy and Management)  |   |   |  |  |                  |                |  |  |
| ASSESSOR'S<br>AFFIDAVIT  | ____ - I am satisfied that the above named applicant meets all the necessary statutory requirements<br>____ - This claim is disallowed for the following reason: _____  |   |  |  |                  |                |  |  |
| SIGNATURE OF ASSESSOR OR MEMBER OF ASSESSOR'S STAFF  |   |   | Date signed (Mo. Day.Yr.)<br>____/____/____  |  |                  |                |  |  |